		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040709

Facility Name: Alden Lincoln Rehab & H C Ctr

Address: 504 W. Wellington Ave. (Number) Chicago (City) 60657 (Zip Code)

County: Cook

Telephone Number: (773 281-6200 **Fax #** (773) 281-6745

IDPA ID Number: 36-4003483

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,417	3,858	4,999	19,274	8
9	SNF/PED					9
10	ICF	7,516	3,517	89	11,122	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,933	7,375	5,088	30,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 03/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 4,633

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	206,618	19,287		225,905	(24,029)	201,876		201,876			1
2	Food Purchase		212,292		212,292		212,292	(21,614)	190,678			2
3	Housekeeping	80,771	22,550		103,321	119	103,440		103,440			3
4	Laundry	47,208	8,888		56,096	130	56,226		56,226			4
5	Heat and Other Utilities			91,937	91,937		91,937		91,937			5
6	Maintenance	51,991		82,977	134,968	102	135,070	5,406	140,476			6
7	Other (specify):*											7
8	**TOTAL General Services**	386,588	263,017	174,914	824,519	(23,678)	800,841	(16,208)	784,633			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,202,682	77,867	2,304	1,282,853	2,907	1,285,760	(469)	1,285,291			10
10a	Therapy											10a
11	Activities	50,455	3,218	1,230	54,903	92	54,995		54,995			11
12	Social Services	36,174		630	36,804		36,804		36,804			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,289,311	81,085	16,164	1,386,560	2,999	1,389,559	(469)	1,389,090			16
	C. General Administration											
17	Administrative	119,476			119,476		119,476		119,476			17
18	Directors Fees											18
19	Professional Services			451,254	451,254		451,254	(408,562)	42,692			19
20	Dues, Fees, Subscriptions & Promotions			15,372	15,372		15,372	(9,589)	5,783			20
21	Clerical & General Office Expenses	319,406	9,965	10,037	339,408	120	339,528	33,471	372,999			21
22	Employee Benefits & Payroll Taxes			270,696	270,696	20,559	291,255	39,224	330,479			22
23	Inservice Training & Education											23
24	Travel and Seminar			359	359		359	6,673	7,032			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,204	55,204		55,204	(2,784)	52,420			26
27	Other (specify):*			(27,081)	(27,081)		(27,081)		(27,081)			27
28	**TOTAL General Administration**	438,882	9,965	775,841	1,224,688	20,679	1,245,367	(341,567)	903,800			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,114,781	354,067	966,919	3,435,767		3,435,767	(358,244)	3,077,523			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr #0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			33,839	33,839		33,839	13,083	46,922			30
31	Amortization of Pre-Op. & Org.							4,129	4,129			31
32	Interest			103,560	103,560		103,560	(71,792)	31,768			32
33	Real Estate Taxes			128,052	128,052		128,052	3,864	131,917			33
34	Rent-Facility & Grounds			728,248	728,248		728,248	340	728,588			34
35	Rent-Equipment & Vehicles			7,299	7,299		7,299	12,670	19,969			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,000,998	1,000,998		1,000,998	(37,706)	963,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							27,081	27,081			38
39	Ancillary Service Centers		189,323	581,278	770,601		770,601	(270,241)	500,360			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		189,323	633,838	823,161		823,161	(243,160)	580,001			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,114,781	543,390	2,601,755	5,259,926		5,259,926	(639,110)	4,620,817			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(1,200)	2		12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,593)	32		18
19	Entertainment				19
20	Contributions	(3,103)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	27,081	38		24
25	Fund Raising, Advertising and Promotional	(5,497)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,449)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 14,239		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(563,610)		34
35	Other- Attach Schedule	(101,632)	p5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (665,242)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (651,003)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Alden Lincoln Rehab & H C Ctr

ID# 0040709

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	American healthcare prior year exp adj backed out	$ 644	20	1
2	Illinois healthcare association - pac fees backed out	(346)	20	2
3	adj ins exp rate audit adj ($29 X #of beds per fac)	(2,784)	26	3
4	Contractual Allowances	(41)	39	4
5	HMO contractual allowance	(32,995)	39	5
6	HMO pharmacy contractual allowance	(9,200)	39	6
7	HMO supply c/a non-cost	(1,614)	39	7
8	Part B contractual allowances	(55,297)	39	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(101,632)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,200)	0	0	(19,214)	0	0	0	0	0	0	0	(20,414)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	5,406	0	0	0	(32)	0	0	0	0	5,374	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,200)	0	5,406	(19,214)	0	0	(32)	0	0	0	0	(15,040)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(13,061)	(469)	0	0	0	0	0	0	(13,530)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(13,061)	(469)	0	0	0	0	0	0	(13,530)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(408,562)	0	0	0	0	0	0	0	0	(408,562)	19
20	Fees, Subscriptions & Promotions	(9,751)	0	162	0	0	0	0	0	0	0	0	(9,589)	20
21	Clerical & General Office Expenses	0	0	15,649	12,925	4,897	0	0	0	0	0	0	33,471	21
22	Employee Benefits & Payroll Taxes	0	0	38,220	0	1,004	0	0	0	0	0	0	39,224	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,673	0	0	0	0	0	0	0	0	6,673	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,784)	0	0	0	0	0	0	0	0	0	0	(2,784)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,535)	0	(347,858)	12,925	5,901	0	0	0	0	0	0	(341,567)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,735)	0	(342,452)	(19,350)	5,432	0	(32)	0	0	0	0	(370,137)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	11,855	0	1,228	0	0	0	0	0	0	13,083	30
31	Amortization of Pre-Op. & Org.	0	0	126	0	0	4,003	0	0	0	0	0	4,129	31
32	Interest	(1,593)	0	(79,274)	0	1,875	7,200	0	0	0	0	0	(71,792)	32
33	Real Estate Taxes	0	0	3,544	0	320	0	0	0	0	0	0	3,864	33
34	Rent-Facility & Grounds	0	0	340	0	0	0	0	0	0	0	0	340	34
35	Rent-Equipment & Vehicles	0	0	12,670	0	0	0	0	0	0	0	0	12,670	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,593)	0	(50,739)	0	3,423	11,203	0	0	0	0	0	(37,706)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	27,081	0	0	0	0	0	0	0	0	0	0	27,081	38
39	Ancillary Service Centers	(99,146)	0	0	(15,249)	(37,696)	(118,150)	0	0	0	0	0	(270,241)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(72,065)	0	0	(15,249)	(37,696)	(118,150)	0	0	0	0	0	(243,160)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,393)	0	(393,191)	(34,599)	(28,841)	(106,947)	(32)	0	0	0	0	(651,003)	45

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$	Alden Management Services, Inc.	100.00%	$ 38,220	$ 38,220	15
16	V	19	Management fees	414,442	Alden Management Services, Inc.		5,880	(408,562)	16
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.		15,649	15,649	17
18	V	6	maintenance/utilities		Alden Management Services, Inc.		5,406	5,406	18
19	V	24	autos/seminars		Alden Management Services, Inc.		6,673	6,673	19
20	V	20	dues/subscriptions		Alden Management Services, Inc.		162	162	20
21	V	30	depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31	amortization		Alden Management Services, Inc.		126	126	22
23	V	33	real estate tax		Alden Management Services, Inc.		3,544	3,544	23
24	V	34	rent		Alden Management Services, Inc.		340	340	24
25	V	35	rent-equipt/vehicles		Alden Management Services, Inc.		12,670	12,670	25
26	V	32	interest	98,940	Alden Management Services, Inc.		19,666	(79,274)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 513,382			$ 120,191	$ * (393,191)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDING	$ 26,382	PYRAMID HEALTH CARE SERVICES	100.00%	$ 7,168	$ (19,214)	15
16	V	10	NURSING SUPPLIES	15,754	PYRAMID HEALTH CARE SERVICES		2,693	(13,061)	16
17	V	39	SUPPLIES / PER DIEM FEES	37,192	PYRAMID HEALTH CARE SERVICES		21,943	(15,249)	17
18	V	21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		12,925	12,925	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,328			$ 44,729	$ * (34,599)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 143,959	Forum Extended Care II	100.00%	$ 112,803	$ (31,156)	15
16	V	10	house stock	2,170	Forum Extended Care II		1,701	(469)	16
17	V	39	iv	30,216	Forum Extended Care II		23,676	(6,540)	17
18	V	22	fringe benefits		Forum Extended Care II		1,004	1,004	18
19	V	21	gen'l and administrative		Forum Extended Care II		4,897	4,897	19
20	V	32	interest		Forum Extended Care II		1,875	1,875	20
21	V	33	real estate taxes		Forum Extended Care II		320	320	21
22	V	30	depreciation		Forum Extended Care II		1,228	1,228	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 176,345			$ 147,504	$ * (28,841)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 454,799	COMMNITY PHYSICAL THERAPY	100.00%	$ 336,649	$ (118,150)	15
16	V	31	AMORTIZATION				4,003	4,003	16
17	V	32	INTEREST				7,200	7,200	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 454,799			$ 347,852	$ * (106,947)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expense	$ 5,138	Alden Bennett Construction	100.00%	$ 5,106	$ (32)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,138			$ 5,106	$ * (32)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President		100.00	349,772	1.794	2.99	Salary	$ 10,779	17	1
2	Lauren Magnussen	Clinical Coordinator		A	78,299	1.3455	2.99	Salary	2,413	21	2
3	Terry Magnussen	Maintenance Supr		A	71,534	1.3455	2.99	Salary	2,204	21	3
4											4
5											5
6	a. President and sole stockholder of Alden Management Services, Inc.										6
7	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,396		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services
Street Address: 4200 W. Peterson Avenue
City / State / Zip Code: Chicago, Illinois 60646-6052
Phone Number: (773-286-3883
Fax Number: (773-286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See pages 8A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RELATED PARTY - CPT/FEC	X		Working capital	NONE					VARIES	9,075	6
7	RELATED PARTY - ams	X		Working capital	NONE					VARIES	19,666	7
8	US Treasury			Working capital							3,027	8
9	TOTAL Facility Related						$	$			$ 31,768	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 31,768	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	169,240	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	145,292	2
3. Under or (over) accrual (line 2 minus line 1).	$	(23,948)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	152,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	128,052	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	163,330	8
	1997	159,440	9
	1998	162,271	10
	1999	161,182	11
	2000	145,292	12

LINE 4: 2001 ACCRUAL BASED ON 3% INCREASE OF ACTUAL BILL PAID IN 2001:

$145,293.32 X 1.03 = 152,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Lincoln Rehab & H C Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-28-108-023-0000	Nursing home facility	$ 145,293.32	$ 145,293.32
2.		Related party - Alden Management	$ 118,551.00	$ 3,544.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 263,844.32	$ 148,837.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAI			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-FECII:			1999	5,015	266	5	266		385	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Sprinkler heads	1995	1,832	73	25	73		458	38
39	Roof repairs	1995	2,000	200	10	200		1,233	39
40	Installed Electric AMPS	1996	1,870	249	5	249		1,870	40
41	Signs	1996	1,800	180	10	180		975	41
42	Water Heater	1997	6,180	1,236	5	1,236		5,562	42
43	Replace Pipes	1997	5,949	1,190	5	1,190		4,958	43
44	Exhaust Fans	1997	8,403	1,681	5	1,681		7,002	44
45	Washing machine motor	1998	1,576	197	8	197		755	45
46	ABC (General construction) Major repairs/improvement	1999	5,713	571	10	571		1,428	46
47	ABC (General construction) Major repairs/improvement	1999	2,326	233	10	233		562	47
48	ABC (General construction) Major repairs/improvement	1999	2,092	209	10	209		506	48
49	ABC (General construction) Major repairs/improvement	1999	1,870	187	10	187		405	49
50	ABC (General construction) Major repairs/improvement	1999	12,658	1,266	10	1,266		2,743	50
51	ABC (General construction) Major repairs/improvement	1999	2,250	225	10	225		469	51
52	ABC (General construction) Major repairs/improvement	1999	10,225	1,022	10	1,022		2,130	52
53	Climate Services (exhaust fan)	1999	2,280	456	5	456		1,026	53
54	Oxygen exhaust system	2000	8,555	1,069	8	1,069		2,050	54
55	Elevator door repair	2000	1,518	304	5	304		456	55
56	Lawn Sprinkler	2000	15,500	620	25	620		827	56
57	ABC (General construction) Major repairs/improvement	2000	6,937	1,387	5	1,387		1,619	57
58	ABC (General construction) New hot water system	2000	49,596	2,480	20	2,480		4,546	58
59	ABC (General construction) Replace showers	2000	23,903	2,390	10	2,390		3,187	59
60	Replace Fire Pump	2001	3,230	162	20	162		162	60
61	14 Kilowatt water heater booster	2001	2,783	93	10	93		93	61
62	ABC (General construction) Major repairs/improvement	2001	3,402	340	5	340		340	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 256,626	$ 20,268		$ 20,268	$	$ 108,339	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,203	$ 19,292	$ 19,292	$	5-15yrs	$ 57,264	71
72	Current Year Purchases	23,612	2,453	2,453		3-10 yrs	2,453	72
73	Fully Depreciated Assets	48,174	1,112	1,112		5 yrs	48,174	73
74								74
75	TOTALS	$ 231,989	$ 22,857	$ 22,857	$		$ 107,891	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	bus/van	1998-2000	$ 11,938	$ 3,797	$ 3,797	$	3	$ 6,200	76
77										77
78										78
79										79
80	TOTALS			$ 11,938	$ 3,797	$ 3,797	$		$ 6,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 500,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,922	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 46,922	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 222,430	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		96	3/1/95	$	15		3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 3/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/02	$ 728,248
13.	12/31/02	$ 728,248
14.	12/31/02	$ 728,248

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,299 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$ 177,348		$	$		$ 177,348	1
2	Licensed Speech and Language Development Therapist	39-3	hrs	29,291					29,291	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	247,541					247,541	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				85,307		85,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): various supplies						(39,127)		(39,127)	13
14	TOTAL			$ 454,180		$	$ 46,180		$ 500,360	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 176,607	$	1
2	Cash-Patient Deposits	8,961		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (75,629))	832,425		3
4	Supply Inventory (priced at)	106		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	50,345		7
8	Accounts Receivable (owners or related parties)	1,225,911		8
9	Other(specify): Real Estate Tax Escrow	81,403		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,375,758	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	263,639		15
16	Equipment, at Historical Cost	164,627		16
17	Accumulated Depreciation (book methods)	(169,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deferred Taxes	62,806		22
23	Other(specify):	288,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 609,101	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,984,859	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,163,920	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,884		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	154,515		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,839		31
32	Accrued Real Estate Taxes(Sch.IX-B)	152,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unpaid assessments	62,531		36
37		3,060		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,669,749	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Rent	332,093		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 332,093	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,001,842	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 983,017	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,984,859	$	48

***(See instructions.)**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 835,835	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 835,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	147,182	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 147,182	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 983,017	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,837,097	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,837,097	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,207	6
7	Oxygen	2,297	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 273,504	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,755	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,614	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,339	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,708	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	70	27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 70	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,125,432	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	824,519	31
32	Health Care	1,372,067	32
33	General Administration	1,224,688	33
	B. Capital Expense		
34	Ownership	1,000,999	34
	C. Ancillary Expense		
35	Special Cost Centers	785,094	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37		(271,819)	37
38		(4,831)	38
39		(5,027)	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,978,250	40
41	**Income before Income Taxes (line 30 minus line 40)****	147,182	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 147,182	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,024	2,080	$ 67,101	$ 32.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,644	23,315	493,316	21.16	3
4	Licensed Practical Nurses	6,606	7,047	115,279	16.36	4
5	Nurse Aides & Orderlies	52,656	56,343	527,256	9.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,072	2,160	33,983	15.73	9
10	Activity Assistants	1,805	1,931	16,472	8.53	10
11	Social Service Workers	1,792	1,968	35,904	18.24	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,160	38,695	17.91	13
14	Head Cook	1,968	2,064	25,346	12.28	14
15	Cook Helpers/Assistants	13,904	15,379	142,578	9.27	15
16	Dishwashers					16
17	Maintenance Workers	1,901	2,093	46,407	22.17	17
18	Housekeepers	8,867	9,417	80,771	8.58	18
19	Laundry	5,183	5,796	47,208	8.14	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,071	4,304	52,168	12.12	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,545	2,689	68,123	25.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical Support	72	80	1,850	23.13	32
33	Other(specify) Personnel	2,024	2,208	40,648	18.41	33
34	TOTAL (lines 1 - 33)	131,190	141,034	$ 1,833,105 *	$ 13.00	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly fee	12,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly fee	2,304	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,230	11-3	44
45	Social Service Consultant	12	630	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	36	$ 16,164		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides		n/a		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Agpasa(2262)/Dalicandro(2018)	administrator	0	$ 4,279
various executives	management	0	34,659
Dipaolo(4109)/Glantz(683.36)	administrator	0	4,792
Palazzo(2229)/Weber(1992)	administrator	0	4,221
Sagaidoro	administrator	0	71,526
	administrator	0	
	administrator	0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,476

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	MNGT. FEES	$ 414,442
Blackman Kallick	ACCT. FEES	6,000
Ken Fisch	Legal Fees	13,364
Barry H. Greenburg	Legal Fees	7,319
Janet Heman	Legal Fees	528
Sachmidt Salzman	Legal Fees	948
Urban Real Estate	Appraisal Fees	3,500
Medi Com	Software consultant	237
Various Misc. Prof. Fees	Misc. Prof Fees	481
U.S. Gas	Utility consultant	936
Healthcare business credit	Financing fees	3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 451,254

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,425
Unemployment Compensation Insurance	5,746
FICA Taxes	146,199
Employee Health Insurance	21,978
Employee Meals	25,331
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	43,235
Chicago head tax	3,744
Dental insurance	533
Employee relations/Payroll misc. costs	1,819
Employee vaccinations	361
Pension / 401 k match	14,887
related party-ams	38,220
TOTAL (agree to Schedule V, line 22, col.8)	$ 330,479

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	23
Health Care Worker Background Check	252
(Indicate # of checks performed 36)	
Fox valley inspections	975
Chicago department of revenue	1,104
Illinois healthcare association	2,400
Misc. dues/subscriptions	867
related party-ams	162
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,783

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	84
Seminar Expense	275
related party-ams	6,673
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,032

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Climate Service-Pipeing	9/95	$ 1,809	5	$ 362	$ 362	$ 241	$ 0	$	$	$	$	$
2	Painting	9/95	2,478	3	551								
3	Painting	11/95	4,500	3	1,250								
4	Painting	12/95	1,497	3	457								
5	Onassis (painting)	1/96	1,369	3	456								
6	Climate Service, Inc.(boil)	1/96	2,015	15	134	134	134	134	134	134	134	134	134
7	Onassis (painting)	2/96	1,541	3	514	43							
8	Great Lakes Plumbing(fix	3/96	1,739	20	87	87	87	87	87	87	87	87	87
9	Onassis (painting)	3/96	1,360	3	453	76							
10	Superior Painting & Déco	3/96	3,400	3	1,133	189							
11	Superior Painting & Déco	5/96	1,626	3	542	181							
12	Superior Painting & Déco	6/96	1,534	3	511	213							
13	Superior Painting & Déco	7/96	1,566	3	522	261							
14	Superior Painting & Déco	7/96	1,671	3	557	279			continued on page 22A, includes grand total…				
15	Superior Painting & Déco	8/96	1,627	3	542	316							
16	Superior Painting & Déco	9/96	907	3	302	201							
17	Superior Painting & Déco	9/96	950	3	317	211							
18	Building Plumbing &Heat	10/96	1,831	15	122	122	122	122	122	122	122	122	122
19	Onassis (painting)	12/96	1,606	3	537	491							
20	TOTALS		$ 35,026		$ 9,349	$ 3,166	$ 584	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn-4195

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 25,331 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 52,560
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet available

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.